# PSJ3

# Exhibit 54A

IN THE CIRCUIT COURT OF PUTNAM COUNTY
WEST VIRGINIA

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MICHAEL MC CALLISTER,
WILLIAM DUFFIELD, and
WILLIAM PETE JONES, II, on behalf
of themselves and all others
similarly situated,

Plaintiffs,

vs. Civil Action No. 01-C-238
Date: August 27, 2004

PURDUE PHARMA L.P., a Delaware
corporation, et al.,

Defendants.

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DEPOSITION OF KATHLEEN FOLEY, M.D.

The deposition of Kathleen Foley, M.D. was taken on August 27, 2004, at the law offices of Chadbourne & Parke, LLP, 30 Rockefeller Plaza, New York, New York before Susan Wandzilak, Registered Professional Reporter and Notary Public in the State of Connecticut.

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117 RANDI DRIVE
MADISON, CONNECTICUT 06443
MADISON, CT 06443 HARTFORD, CT 06106
203-245-9583 800-839-6867

A P P E A R A N C E S

MARK A. COLANTONIO, ESQUIRE
Frankovitch, Anetakis, Colantonio & Simon
337 Penco Road
Weirton, West Virginia 06062-3828
Attorney for Plaintiff

WILLIAM HOFFMANN, ESQUIRE
King & Spalding
191 Peachtree Street
Atlanta, Georgia 30303
Attorney for Defendants
Purdue Companies

PAUL T. FARRELL, ESQUIRE (via conference call)
Farrell, Farrell & Farrell, L.C.
Post Office Box 6457
Huntington, West Virginia 25772-6457
Attorney for Defendant Jimmy
Adams, D.O. And James R.
Toothman, D.O.

DOREEN SEAMON, ESQUIRE (via conference call)
Colombo & Stuhr
1054 Maple Drive
Morgantown, West Virginia 26505
Attorney for Defendant
Dr. Louis Ortenzio

RAMONDA LYONS, ESQUIRE
Dinsmore & Stohl, LLP
Huntington Square, Suite 600
900 Lee Street
Charleston, West Virginia 25301
Attorney for Defendants Purdue
Pharma, LP, The Purdue
Frederick Company, Purdue
Pharmaceuticals, LP, The P.F.
Laboratories, Inc., and PRA
Holdings, Inc.

STEPHANIE DOBBINS, ESQUIRE
Goodwin & Goodwin, LLP
300 Summers Street, Suite 1500
Charleston, West Virginia 25301
Attorney for Defendants, Abbott
Laboratories and Abbott
Laboratories, Inc.

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the parties that each party reserves the right to make specific objections at the trial of the case to each and every question asked and of answers given thereto by the deponent, reserving the right to move to strike out where applicable, except as to such objections as are directed to the form of the question.

IT IS HEREBY STIPULATED AND AGREED by and between counsel representing the respective parties that proof of the official authority of the Notary Public before whom this deposition is taken is waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing the respective parties that the reading and signing of the deposition by the deponent is not waived.

IT IS FURTHER STIPULATED AND AGREED by and between counsel representing parties that all defects, if any, as to the notice of the taking of the deposition are waived.

Filing of the Notice of Deposition with the original transcript is waived.

I N D E X



E X H I B I T S

THE VIDEOGRAPHER: This is the videotape deposition of Kathleen Foley, M.D, taken in the case of Michael McCallister, et al versus Purdue Pharma filed in the Circuit Court, August 27, 2004. The time on the videotape record is 8:11 a.m.

This deposition is being held at Chadbourne & Parke, LLP, 30 Rockefeller Plaza, New York, New York. My name is J.D. Martinez on behalf of Hamilton Communications of 60 Pine Lake Road, Westbrook, Connecticut.

Would everyone please introduce yourselves for the record.

MR. COLANTONIO: Mark Colantonio representing plaintiffs.

MR. HOFFMANN: William Hoffmann representing the Purdue defendants.

MS. LYONS: Ramonda Lyons representing the Purdue defendants.

MR. FARRELL: Paul Farrell representing Dr. Adams and Dr. Toothman.

MS. DOBBINS: Stephanie Dobbins representing the Abbott Laboratories defendants.

KATHLEEN FOLEY, M.D.,

Having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. COLANTONIO:

Q. Can I have your full name and address for the record.

A. Kathleen M. Foley, [redacted].

Q. Good morning.

A. Good morning.

Q. Are you currently employed or are you self employed?

A. I am currently employed.

Q. Employed by whom?

A. By Memorial Sloane-Kettering Cancer Center.

Q. And, what is your position there?

A. I am an attending neurologist in the Department of Neurology.

Q. You are actually employed by the hospital itself?

A. That is correct.

Q. Have you ever been employed by any of the Purdue pharmaceutical companies?

A. No, never.
Q. Have you ever been employed by any pharmaceutical company in any capacity?
A. No, I have not.
Q. Have you ever testified by way of deposition or trial testimony prior to today?
A. I think I did and I can't remember the exact details. It was in the eighties and it was a case related to the drug hydromorphone and a discussion of whether it should be available for any company to make. But I don't, you know, I don't remember all the details of it. I am not sure if it was a deposition or just I appeared in court once. And that's all that I can say about it.
Q. And, that was back in the eighties?
A. It was in the eighties, yeah.
Q. Since that time, you can't recall any time when you have actually testified in court or in deposition for any reason?
A. No.
Q. Have you ever been provided any monetary grants or funding from any drug company to do research work or any other work?
A. Yes, I have. I have been on the

speakers bureaus of various drug companies over the years including Purdue and Abbott and Noel and Janssen. And I have -- I have not directly received grants from these companies but my institution has.

Q. Sloan-Kettering?

A. Yes.

Q. And, can you give me an idea of some of the types of grants Sloan-Kettering might receive from drug companies?

A. In the, again, in the early eighties, we were involved in extending a slow release morphine preparation. Subsequent to that, I have not been involved in studying any of their drugs so I have not received them.

Q. You say in the early eighties there was some involvement with slow release morphine?

A. Right.

Q. And, tell me more about that?

A. The -- our particular analgesic group is well-known for studying opiate analgesics and we care for a large number of patients with pain and cancer. And we had a large national cancer institute grant to study these drugs. And so within that framework of a large study group, we

did study the oral morphine preparation MS Contin but we did not simply study it for Purdue. We studied it for a variety of other companies.

Q. But, the study was limited to MS Contin?

A. It was limited to slow release or morphine preparation.

Q. You mentioned MS Contin, was there another?

A. Yes, there was a product that Roxanne also had.

Q. And, was that study published?

A. Parts of it were published.

Q. When was it published?

A. I would have to specifically look at it.

Q. But, it would be in the eighties, is that correct?

A. In the eighties, yeah.

Q. Any others that you can recall, besides that?

A. No. No other studies, no.

Q. The speaker bureaus you mentioned, you mentioned speaking for Purdue, Abbott, Noel and Janssen?

A. Um-uh.

Q. Is that something that occurred in the

eighties and the nineties or eighties --

A. Yes, both. I would say in the eighties and nineties. It no longer exists so it is not an issue and it predominantly was speaking at medical grand rounds where the grand rounds, people were given the money, I wasn't. Then they paid me whatever they paid me.

Q. Let's talk about Purdue, specifically. Have you ever given any talks to Purdue employees, for example?

A. I think probably, again, in the eighties that would have related to oral morphine perhaps once.

Q. And, do you recall how many talks that would be or a time frame?

A. Oh, perhaps one.

Q. And, was that something where you would speak about something like MS Contin or --

A. No, in fact it was speaking about cancer pain in general.

Q. And, in your, I reviewed your resume, your curriculum vitae, and is it true that your primary practice has been devoted towards the treatment of cancer and cancer related pain?

A. I think -- I think it's better

characterized by the use of opioids in pain management of which the cancer patient has been the predominant patient.

Q. But, your predominant work has been treating, using opioids in the management of cancer pain; true?

A. The majority of our patients have had cancer pain.

Q. Do you currently treat patients who have non-cancer pain?

A. Yes, I do.

Q. And, what part of the practice of that is yours now?

A. Again, it is quite variable. In the beginning, when I first started in the 1970s and 80s, I would say perhaps half of our patient population had non-cancer related pain. At the present time, I still follow many of those patients but probably it's maybe about 30 percent of our patient population have non-cancer pain.

Q. Do you treat things like back pain?

A. Yes.

Q. Non-cancer back pain?

A. Um-uh.

Q. How about non-cancer arthritis pain?

A. Yes.
Q. Non-cancer muscular skeletal pain?
A. Right.
Q. Broken bones, pain related to that?
A. Usually not. But, I think, again, it's important to recognize that because cancer patients are living longer and longer, they have a variety of chronic pain syndromes that are not directly related to their cancer. But because they are cared for in a cancer center, we see them. So we are seeing a larger number of those survivors who have these other disorders.
Q. But, with you seeing these patients related to or in connection with you seeing them for cancer pain as opposed to having a practice where people come in for back pain, solely back pain as opposed to cancer pain?
A. I am trying to make the distinction that cancer patients have pain other than cancer. So in the cancer center, the pain clinic is seeing a much more broader -- initially it was a smaller percentage and now it is a much broader percentage.
Q. Maybe it's a distinction without a distinction but I am trying to understand whether

somebody would -- I presume most people go to Sloan-Kettering to see your group primarily for cancer related issues; is that correct?

A. That's true, right.

Q. And, those patients may have other issues in their life besides cancer caused pain?

A. Right.

Q. Maybe they have had a long standing problem with a back or whatever and you might treat them for that as well; is that true?

A. That is correct, yes.

Q. As opposed to for somebody who might come in for back pain who doesn't have cancer?

A. That is correct, sure.

Q. Have you ever given talks to Purdue employees about OxyContin?

A. No, I have not.

Q. Have you ever given any talks at all, lectures, seminars, ever appeared anywhere concerning the drug OxyContin?

A. No, I have not.

Q. You do have privileges at New York Hospital; is that correct?

A. That's correct.

Q. Are those active staff privileges?

A. Yeah.
Q. And Manhattan Eye & Ear Hospital, are those active staff privileges?
A. No longer, no.
Q. Do you have any staff privileges there at Eye & ear?
A. No.
Q. How about Rockefeller University?
A. No, not at the present time.
Q. How about Calvary?
A. Not at the present time. We have a fellowship rotation but we are not required --
Q. So, primarily, right now -- well, in fact, the two hospitals you have staff privileges, active staff privileges, would be Sloan-Kettering and New York Hospital; is that correct?
A. That is correct, um-uh.
Q. Just as an aside, when we take this deposition, if you could let me finish my question before you start to answer. And I will try to let you finish your answer before I ask my next question so that the transcription will come out better.
A. It will be faster.

Q. I noticed in your CV, you had for 1988 to 1992, Bristol Meyers unrestricted grant program for pain research?

A. Right.

Q. Is that what you were referring to before or is that something else?

A. It was a grant from a pharmaceutical company. It was an unrestricted grant.

Q. And, what was that grant given for?

A. It was one of the awards that Bristol Meyers gives out for pain research and they typically would give out five a year over about a five or seven year period. And so we were chosen as one of the recipients of it. And it was for $50,000 a year for five years that we could do with as we wished to support any aspect of our pain research.

Q. I also noticed you served on a committee of the National Institute on Drug Abuse and that was from 1986 to 1988; do you recall that?

A. Yes, I do.

Q. And, you served on the committee of problems of drug dependence; do you remember that?

A. Yeah, the committee of problems of drug

dependence is an association that focuses on the pharmacology of opioid drugs.

Q. Does it deal with issues of drug addiction?

A. It deals with drug use and drug misuse.

Q. Maybe that answered my question, maybe it didn't, I don't know. I mean, it says here committee of problems on drug dependence. What does -- in the context of that committee, what does drug dependence mean?

A. Well, the -- well, I said drug use and misuse. And so what I mean, the whole gamut of the appropriate use of drugs and the inappropriate use of drugs and drug addiction would be included in that.

Q. So, in the context of this Committee on Problems of Drug Dependence, the word drug dependence in that context would include drug addiction?

A. Yes, it will. Yes.

Q. And we are going to talk about this a little bit but do you believe there is some potential confusion and commingling of terms like addiction, dependence, abuse in terms of drug use?

A. Could you repeat the question?
Q. Sure. We will talk about this a little bit later, but generally do you believe that in the treatment of pain that there is often confusion among physicians and patients, definitional confusion, with the terms drug addiction, drug dependence, drug abuse?
A. I do.
Q. And that's still true today; is that correct?
A. Yes.
Q. What was it -- in terms of drug addiction, what was it this Committee on Problems of Drug Dependence studied or did?
A. I think what I am attempting to say is that it's called a committee but it is really an association.
Q. Okay.
A. So, it has an annual meeting. Papers are proffered at that annual meeting. It has annual discussions. It is not --
Q. Everybody goes to dinner and exchanges information and --
A. It's usually not dinner but clearly everybody meets for several days and it's an

academic -- it's an academic society at this point in time. So it is still called by this name committee.

Q. But, there was no actual research done by that committee or reporting by that committee, it was more of an exchange of information?

A. It was an exchange of information.

Q. Was it a committee that would come up with any kind of conclusions after the exchange of information or was it merely just an exchange of information?

A. Again, it's -- it's a meeting of a group of individuals who have an interest in studying these drugs. So the language of committee, it doesn't have a task to issue conclusions. That's not the purpose of it. It is a society at this point in time. You pay membership dues. You participate in the meetings and it does issue reports.

Q. That was my -- that was the intent of my question. When you say it issues reports, what type of reports would it issue?

A. I don't think I fully know that because I have only been involved with one report that is issued, so --

Q. I am sorry, one report?
A. Yes.
Q. What report was that?
A. This is an issue that was to focus on the use and abuse of opioid analgesics.
Q. And, when was that report issued?
A. I forget. In the last two years or so.
Q. You say within --
A. It's on my CV. I would have to look at the exact date.
Q. And, that's 2002 to 2004?
A. Yeah, I don't remember the exact date of it.
Q. I am just asking you, like when you say the last two years, you meant the last two years prior to today?
A. I would have to look at my CV because -- I mean, I am glad to give you the exact date.
Q. Let me give you a copy of your CV.
A. Okay, great. Thanks.
Q. Take a look at that and take a copy there.
A. Well, I wouldn't say this is -- well, this is not my updated CV, I guess.
Q. There was something I believe in the

back that said in press and there was maybe three or four different things, although I think that related to your own materials. I don't know if that -- here, the last page has --

A. Well, it's someplace after 2001 so this is not my updated CV.

MS. LYONS: Is your updated CV over here?

MR. COLANTONIO: That's fine, we can work through it.

BY MR. COLANTONIO:

Q. You recall sometime after 2001 there was a report issued --

A. Right.

Q. -- by the National Institute on Drug Abuse?

A. No, it is not the national. No, it was the Committee on Problems of Drug Dependence.

Q. And, you were involved in that?

A. Correct.

Q. And, what was your involvement?

A. I was one of the task force members.

Q. And, do you recall what the findings of that particular report were?

A. Yeah, but I would need the report to

tell you the findings.

Q. Sure. You also have worked with the World Health Organization, I see?

A. That is correct.

Q. That's also known as WHO, W-H-O?

A. That is correct.

Q. And, we have seen that W-H-O or WHO had developed a step ladder approach to the treatment of cancer pain. Do you recall that?

A. Yes, I was the chair of the committee that developed the WHO analgesic ladder.

Q. And, it has step one, step two and step three, is that --

A. That is correct.

Q. Is that still used today?

A. The WHO ladder was initially developed in guidelines in 1982 and then field tested from about 1984 to '86 and then put forth as guidelines in 1986. And it has now been expanded to focus not only on cancer pain but on patients with chronic non-malignant pain, patients with AIDS pain, pain care for children and pain for the elderly.

So, the WHO has robustly expanded the importance of this three step analgesic ladder.

Q. So, as far as non-cancer pain, it has been expanded to include chronic non-malignant pain?

A. That is correct.

Q. And, what is meant by the word chronic?

A. The International Association for the Study of Pain has defined chronic pain as pain lasting greater than three months.

Q. And, do you use that definition of chronic in your practice?

A. I think using the IASP terminology is important so then it makes sure that everybody agrees that we are talking about the same kind of pain. However, not everyone follows that terminology.

Q. But, as far as those in the know, in the treatment of cancer pain or --

A. Well, this is for all types of pain. This is unrelated to cancer pain.

Q. So, as far as those in the know in the treatment of pain, chronic, the accepted definition of chronic is more than three months?

MR. HOFFMANN: I object to the form of the question.

BY MR. COLANTONIO:

Q. Do you understand my question?

MR. HOFFMANN: You can answer it, if you're able to.

THE WITNESS: Could you ask me the question again?

BY MR. COLANTONIO:

Q. Sure. Is it true that the accepted definition of chronic pain in the pain management field, as far as you are aware, is greater than three months?

A. Well, the IASP terminology says three months but people use six months, people use nine months.

Q. But it's something greater than three months, generally accepted; is that right?

A. The IASP terminology is three months.

Q. And, that's the definitional time frame that you would use in your practice of treatment of pain for the term chronic?

A. Yes.

Q. The WHO step ladder, I have seen a couple of different I guess charts with this?

A. Right.

Q. It has a little step ladder and it has step one and then step two and step three. And,

step one is what type of pain? Is that --

A. Step one is for mild pain.

Q. And, is step two mild to moderate?

A. And then step two is moderate pain.

Q. And, step three?

A. Is severe pain.

Q. Now, I have seen different step ladders that have step two being mild to moderate. Is that an accurate way of portraying it?

A. Well, I think the -- any of the kinds of schematics that you have seen always try to over simplify the issue. So, the step one is thought to be for patients with mild to moderate pain. Step two is for patients with the end of mild to moderate to severe and then severe at the end.

And so the difficulties, we have chosen and used those three words in focusing on that and the principle of the ladder is that one would treat pain based on the intensity of the pain. So if a patient has mild pain, you would use a certain class of drugs. If they had moderate pain, you would use another class of drugs. And if they had severe pain, you would use a third class of drugs.

Q. And, for mild pain, what class of drugs

would you use?

A. Typically, it has been the non-opioid analgesics.

Q. So, as far as the WHO step ladder is concerned, the WHO step ladder does not advocate using opioid medication for mild pain; is that fair?

A. Again, the ladder is very flexible because it identifies that there may be some patients who are just unable to take a non-opioid and who might require taking a what we would call a weak opioid.

Q. What is a weak opioid?

A. Well, the classes of drugs that the WHO defined as weak opioids were codeine, hydrocodone, oxycodone, tramadol and those are what are listed now on the essential drug list.

Q. As far as oxycodone, would that be oxycodone in combination with an aspirin product?

A. No, the WHO made a very strong statement that it was addressing specifically the opioid and not a combination drug.

Q. So, if I see a step ladder that has step two being mild to moderate, you don't think that's an accurate portrayal of the step two?

A. Can you --

Q. Sure. If I see a picture of the WHO step ladder and it has step two --

A. Um-uh.

Q. -- at the beginning including mild, at the end including moderate pain, so step two is portrayed as including mild to moderate pain, would that be an inaccurate way of portraying it?

A. No, I don't think it would be. I mean, I would have to see it to answer the question. I don't know even seeing it would help me. I think the point I am making is there is this continuum. There are patients who could report mild pain but could report it as a four. There are patients that have moderate pain that might report it as a four. So, because of this overlapping aspect, the ladder was thought to be a flexible approach and that you needed really to individualize the treatment of patients.

And, so, therefore, I would be somewhat -- how people have demonstrated the ladder is not how we thought it should be used and how we described it.

Q. Pain is subjective, of course; is that correct?

A. It's a subjective experience, right.

Q. And, often difficult for physicians to assess in terms of the quantity of pain; is that correct?

A. Well, again, we ask physicians to believe the patient's pain and then to do a very thorough assessment so that they can try to assess the intensity of the pain and the impact of the pain on the patient and the patient's functional status and try to use all of that. So simply a report of pain isn't enough for the doctor to be able to make a decision about the patient.

Q. You indicated that physicians should do individual assessments. That's true in every type of physician patient treatment, physicians must evaluate their patients on an individual basis; correct?

A. That is correct.

Q. And, that would be true for every medication that a physician ever writes for a patient, they should evaluate the appropriateness of that medication for that particular patient; true?

A. Well, I think -- yes, that's true.

Q. Now, in your bibliography here, I noticed that you have written quite a few articles with Dr. Kaiko; is that correct?

A. Dr. Kaiko, um-uh.

Q. And, Dr. Kaiko, is that the same Dr. Kaiko that works for Purdue?

A. Right, that was before he went to Purdue.

Q. And, was he at Sloan-Kettering at that time when you worked with him on these pictures?

A. When I came to Memorial, Dr. Kaiko was already there.

Q. And, do you still -- you know of Dr. Kaiko; correct?

A. I know Dr. Kaiko.

Q. Do you still maintain contact with Dr. Kaiko?

A. Not that frequently.

Q. Have you ever gone out socially with Dr. Kaiko, let's say, in the last five years?

A. No, I haven't.

Q. You do on occasion maintain professional contact with Dr. Kaiko?

A. Yes, I do.

Q. And, what's the reasoning for that or

what is the --

A. Well, about a year ago he came to our conference that we had on opioid analgesics. So that would be about the last time I saw him.

Q. Have you maintained any other professional contacts with any other people that work at Purdue, let's say, in the last five years?

A. Could you tell me what you mean by that?

Q. Sure. Well, I mean, have you ever had meetings with or spoken to people from Purdue and that's for any reason in the last five years. You have indicated that Dr. Kaiko might have seen you at a meeting and you might have --

A. Right, and I would see other people from Purdue at various meetings.

Q. How was it that you became involved in this particular case, did somebody contact you and ask you?

A. Yes, I am not sure who contacted me. I know that the lawyers called me up and asked me do this. So that's what I remember and I don't specifically remember who asked, who the person was that asked me first or --

Q. And, when you say do this, you mean --

A. To participate in this case, sorry.
Q. And, what was your assignment; do you recall that?
A. I am sorry?
Q. Do you recall what your assignment was, your assignment was, what they told you they wanted you to do?
A. I need my piece of paper. That's what I said I would do -- was to be an expert witness, I am sorry.
Q. I want to show you an article here. Take a look at that. I think that's something that you authored in 1985. Do you recall that?
A. Yes, I do, um-uh.
Q. Now, you won't know this but in this case, there were documents produced by Purdue and I believe that came from you; is that correct, the source?
MS. LYONS: Yes.
BY MR. COLANTONIO:
Q. The bottom of this article has these numbers on it. Do you see the bottom right, they are called Bates numbers. Do you know what that is?
A. No, I don't. I have seen --

Q. It just has numbers. Do you see the numbers?

A. I see the numbers there, yeah.

Q. And, I think if you look at this, the top of this says opioid studies written by Purdue employees and then I believe where the source is Susan Nick?

MS. LYONS: Yes, I see.

MR. COLANTONIO: These Bates numbers correspond on this article to that.

BY MR. COLANTONIO:

Q. Do you know a Susan Nick?

MR. HOFFMANN: Just, the Bates numbers don't correspond precisely. The end Bates number is two numbers higher on the source log that you handed me than on the --

MR. COLANTONIO: What is your last Bates number?

MR. HOFFMANN: On 47.

MS. LYONS: On the article is 47.

MR. HOFFMANN: Rather than 49.

MR. COLANTONIO: I have 49 including the --

MS. LYONS: The copy you gave us doesn't --

MR. HOFFMANN: What is your last --

MR. COLANTONIO: My last page is 49 on the footnotes.

MR. HOFFMANN: Well, you only included the first page. You didn't include all the pages of the footnotes in the copy you gave us.

MR. COLANTONIO: I apologize for that. Why don't you take a look at mine. Without the source log, I think --

MR. HOFFMANN: Yes, the Bates numbers do in fact correspond with the second copy that you handed me.

BY MR. COLANTONIO:

Q. Okay, well, let me show you this document and I know you have never seen this before but that is a log, a source log, of materials produced by Purdue in this case. And at the top, it says their accounts, their source log, opiate studies written by Purdue employees. Do you see that?

A. I see that.

Q. And, then down, there is a source that says Nick, Susan, do you see that?

A. I see that.

Q. And, to the left of that, there is a Bates, begin Bates and end Bates; do you see those numbers?

A. I see those numbers.

Q. Can you compare those begin and end numbers to the numbers on the article that I handed you?

A. Yes.

Q. And, does it appear that those numbers coincide with that?

A. Yes, those numbers coincide with -- no, that says 49 and that says 47.

MR. HOFFMANN: With the exception that I stated on the record, that two of the pages of the footnotes are missing from the copy that you have handed the witnesses -- the witness.

BY MR. COLANTONIO:

Q. And, you have indicated you don't know a Susan Nick; is that correct?

A. No, I don't know a Susan Nick.

Q. And, you have testified you have never been an employee of Purdue, is that correct?

A. I have never been an employee of it.

Q. But, you did author this article; is

that true?

A. I wrote this article by myself and I have never heard or seen it.

Q. These are your words in this article?

A. These are all my words. These were never seen by any external writer. I find this very insulting, I want you to know. I mean, this is like an out-and-out lie. So, I am very bothered by that.

MR. HOFFMANN: It's possible -- of course, there are a number of possibilities. One is the document was misfiled and came from an inappropriate file. But obviously --

THE WITNESS: I mean, that is so serious.

MR. HOFFMANN: Let me finish. Obviously to the extent that the implication of your question might be this document was authored by someone at Purdue rather than the witness, I think the witness's testimony on that point is clear. And we all know that when we deal with cases with thousands and thousands of documents, occasionally documents are misfiled or they are mis-labeled concerning the file that they originate from.

MR. COLANTONIO: And that's fine. I mean, look, I didn't ask the question to try to upset you in any way. You have to understand that what happens in these cases is I get materials from Purdue and that's what it says. And I am merely asking a question trying to clarify it.

THE WITNESS: I understand.

MR. COLANTONIO: So, there is no -- I mean, I am not trying to mislead you in any way. I was produced materials that had that source log which we didn't prepare and it had that information on it. So I am merely asking the question to clarify it and I think you have clarified it, okay.

THE WITNESS: All right; and, I have a series of people who would be glad to clarify it for you.

MR. COLANTONIO: And, I am sure you do but I just want you to understand that I am just asking the question to try to clarify the issue, that's all. And that was produced to me.

THE WITNESS: Okay.

MR. HOFFMANN: And I will state on the

record that I will ask our people who produce documents to go back and check and determine what the source of the error on the source log was --

THE WITNESS: Thank you.

MR. HOFFMANN: -- and provide you with that information.

BY MR. COLANTONIO:

Q. Getting back to the question, which was this is your article?

A. That is correct.

Q. And, the title of the article is, medical progress, the treatment of cancer pain; is that correct?

A. That is correct.

Q. And, this was published in the New England Journal of Medicine in July of 1985; is that true?

A. That is correct.

Q. And, do you recall this particular article, writing it and --

A. I recall it in great detail.

Q. And, do you believe that the information and your thought process and your thoughts in this article are as true today as they were back

in 1985?

A. I think there has been an evolution of what we know. So I think it was the state-of-the-art for 1985.

Q. And, we will go through that. Are there some things in here that you believed in 1985 that you don't believe are true today?

A. I would have to go practically line by line to answer that question.

Q. Let's do some of that in here. If you go to the second page -- well, it's page, actually page 85 of the article.

A. Okay.

Q. It's in the top right, do you see that?

A. Right.

Q. There is a part of this article that says types of pain?

A. That's right.

Q. And, I think you have indicated this article was written for cancer pain, is that correct?

A. It's called the treatment of cancer pain.

Q. But, you do make some statements that apply to the treatment of pain in general in this

article; is that true?

A. That is correct.

Q. Now, on types of pain, on the first column, if you look down, the first paragraph for types of pain --

A. Um-uh.

Q. And we talked about this very briefly before. It says here pain is a subjective experience, and you agree with that statement?

A. That is correct.

Q. And, that's as true today as it was in 1985; right?

A. Yes, um-uh.

Q. And, it says here evaluation of it is difficult?

MR. HOFFMANN: I am sorry, you are on the first column on page 85?

MR. COLANTONIO: Yes, right here (indicating).

MR. HOFFMANN: Because pain is a subjective experience, evaluation is difficult, all right.

BY MR. COLANTONIO:

Q. Do you see that?

A. Yes, I do, um-uh.

Q. And, do you agree that that is as true today as it was in 1985?

A. No, things are much better now.

Q. Well, which part of it do you think is different now than --

A. Well, pain remains a subjective experience but the evaluation of it is much more sophisticated.

Q. Evaluation of pain is much more sophisticated by physicians in general or by specialists or by --

A. By physicians in general because they have now available a wide variety of techniques that they didn't have at that time. In 1985, they didn't have MRI scans. In 1985, they didn't have sophisticated qualitative sensory testing devices. In 1985, they didn't have PET scans. I mean, there is some technological advances that have really influenced how one evaluates the patient.

Q. But, those technological advances you are talking about are ways physicians can objectively verify a complaint of pain; is that correct?

A. Yes, but that's the necessary step to

treating the pain.

Q. That's treating the cause of the pain; true?

A. Treating the pain as well, because often treating the cause treats the pain.

Q. But, there are sometimes when you can treat the cause of the pain and the pain doesn't go away for a patient?

A. That's true.

Q. But, as far as verifying a patient's subjective complaint of pain, do you agree that that's still today sometimes a difficult task for physicians?

A. It can be a difficult task.

Q. Especially for physicians such as primary care physicians who may not be pain specialists?

A. Again, since the whole development of sort of the progression of evaluating pain where physicians are in a much better position now to evaluate pain because they are being increasingly more educated about how to assess pain.

So that in 1985, the Academy of Family Physicians didn't address pain issues. 2004, the Academy of Family Physicians has written

educational materials for how physicians should assess pain. So, it's really a much better world that we are in now than we were then.

Q. And, I think you have included some of those materials and you brought some of those today, is that correct? There are a few articles from --

A. There is a -- their web site has a lot of material that they have.

Q. Written in the last couple of years?

A. In the last couple of years, yeah.

Q. And, it says here, the patient -- the next sentence down, the patient and physician are best served if the physician believes the patient's report?

A. That is correct.

Q. And that's as true today as it was in 1985?

A. Absolutely.

Q. Now, the next paragraph down, you sort of define acute pain and chronic pain. And you say that chronic pain is pain that persists longer than six months --

A. Right.

Q. -- in which adaptation of the autonomic

nervous system occurs. That's a little different than the definition you gave before of three months.

A. That's correct because the --

MR. HOFFMANN: Wait a minute, I want to object to the form of the question just because you misread one word. I think you misread autonomic, but I could be mistaken.

MR. COLANTONIO: If I misspoke, I didn't mean to leave that word out. I thought I said it but let's read it again so we are sure.

THE WITNESS: Okay.

BY MR. COLANTONIO:

Q. It says here, in contrast chronic pain is pain that exists longer than six months -- and that's really the phrase I am focusing on. That six months, it's a little different time frame than you indicated you use today which is three months; is that true?

A. That's correct, because, again, the ISP has adapted their terminology. They didn't have a clear terminology for chronic pain and moved to adapt a three month terminology.

Q. Was chronic pain generally considered

six months or longer back at the time when you wrote this article, in your practice?

A. You know, I think -- well, if I said it, I said it. But, I would have to be -- it was sort of a common belief perhaps at that time.

Q. It was your belief at that time.

A. I guess so, it was my belief at that time.

Q. That's why you said it, I assume?

A. I think what I am not sure is I would have to look at the ISP terminology to see how it was being defined. And it's possible I didn't reference it so I would have to go back to my references. It is possible that I was referencing John Benika's (ph) work on the topic and he used six months. So I just don't remember that.

Q. On the next column, it talks about -- and this is sort of at the mid to the bottom of the page. It talks about psychological factors play an important part --

A. Right.

Q. Would you agree that psychological factors can play an important part in pain for a patient?

A. Well, the sentence I have there is they play an important part in this group of patients.

Q. I understand. I asked a different question.

A. Okay, so tell me what the question is then. I am sorry.

Q. The question was, do you agree that psychological factors can play an important part in a patient's pain?

A. Yes.

Q. And, would those psychological factors include things like emotional factors that may be present in a patient's life?

A. Yes.

Q. Would those psychological factors include social issues that may be present in a patient's life?

A. Yes.

Q. Would those psychological factors include financial issues that may be present in the patient's life?

A. Well, I wouldn't call them psychological factors. I would call them financial factors.

Q. Would financial -- do you believe the financial factors can play a role in a patient's

pain?

A. They can. Sure, yes.

Q. And, if you look down here, you talk about, in the middle of the paragraph, Saunders, you cite, using the phrase total pain, do you see that?

A. Saunders has used the phrase total pain.

Q. And, do you agree with that concept?

A. Of total pain?

Q. Yes.

A. Yes, I agree with that concept.

Q. And, does that mean that in addition to some physiological ideology of pain like a broken bone, that somebody could have emotional, social, bureaucratic or financial factors that might effect how that patient perceives their pain?

A. Yes, and I would like to use your language of factors rather than call them pain. I don't think there is such a thing as financial pain or spiritual pain. So I don't agree with Saunders by using the word pain in that context.

Q. So, you agree with me?

A. I agree that there are financial factors, psychological factors, social factors, yes.

Q. What does he mean by spiritual pain?
A. What does Dr. Saunders mean by spiritual pain?
Q. When you wrote this, you cited him but you used the word spiritual --
A. It's not a him, it's a she.
Q. I'm sorry, you used the word spiritual pain. What did she mean or what did you mean?
A. She means existential distress.
Q. What is existential distress?
A. The sense of meaning, sense of hope, sense of hopelessness that patients might experience that can influence their --
Q. So, in your experience, a patient who might have some sort of even spiritual hopelessness or hopelessness that might be brought about by other factors in their life, that might tend to exacerbate their feeling of pain or have a factor in their perception of pain?
A. It is a factor in their life and it may have an impact on their pain.
Q. And, these factors we talked about, the financial, the spiritual, the emotional, could they cause a patient to exacerbate their

perception of pain they are experiencing?

A. They may.

Q. And, these are things I presume that you believe that should be taken into consideration when one evaluates a patient with pain; is that true?

A. That is correct.

Q. And, that's done through history?

A. It's done in a variety of ways but taking a history is one way.

Q. The financial factor we just mentioned, would that tend to mean that if a person is in a worse financial state or in a poor financial state, that that person may have an increased perception of their pain?

MR. HOFFMANN: Object to the form of the question. If you can answer it, go ahead.

THE WITNESS: Could you say the question again?

MR. COLANTONIO: Sure.

BY MR. COLANTONIO:

Q. If a person is in poor financial condition, would you agree that that poor financial condition may be a factor in how that person perceives the pain they may be

experiencing?

A. No, I don't think I would like to describe it that way. It could influence how -- it clearly could influence the treatment they receive. It can clearly influence their ability to obtain treatment because they can't pay for it. I don't think I have any clear data to say that it could influence their perception of pain.

Q. Well, when you say it's a factor, I think you just told me before it was a factor?

A. It is a factor, yeah.

Q. But, how is it a factor?

A. Well, if you can't -- a very classic example is a patient can't afford to buy their pain medication so they end up in significant pain all the time because they can't afford to buy it. It's a very real factor because the fact that they can't buy their drugs means they stay in pain all the time.

Q. But, that's a factor in the treatment of pain. What I am talking about is whether or not a financial condition or emotional condition, somebody is depressed, somebody is ready to file bankruptcy --

A. Right.

Q. Isn't it true that that can actually cause the patient to feel as though they are in more pain than they otherwise might feel?

MR. HOFFMANN: I object to the form of the question.

BY MR. COLANTONIO:

Q. Do you understand my question? It's not that they can't pay for the prescription. It is that the financial condition or the emotional distress they have, they are going through divorce or something like that, that might cause them to perceive more pain than they otherwise would?

MR. HOFFMANN: I object to the form of the question.

BY MR. COLANTONIO:

Q. You can answer if you can.

MR. HOFFMANN: You can answer.

BY MR. COLANTONIO:

Q. Do you understand what I am asking?

A. Yes, I mean, I will try to answer but I am not sure I can answer it in this construct. I don't separate out the treatment aspect from an assessment aspect. In a sense, they are very very closely tied. And so if a patient has

financial difficulties, that may influence their mood. That may influence their social interactions.

So, I don't think that we have evidence that it directly effects their perception of pain. I think we have evidence that it indirectly effects the experience of pain. And so I would rather describe it as an indirect experience of pain rather than a specific demonstration that it makes them have more pain or less pain.

Q. Now, on page 87 of the article, there is a discussion about drug therapy. Do you see that, the second column?

A. I am sorry, which column?

Q. The second column on page 87.

A. Okay.

Q. And, it says non-narcotic agents?

A. Yes.

Q. And those would be non-opioid agents, is that correct?

MR. HOFFMANN: No objection, go ahead.

MR. COLANTONIO: I am sorry, I didn't know if you answered the question or not.

THE WITNESS: So ask me the question.

BY MR. COLANTONIO:

Q. Would non-narcotic agents be non-opioid agents?

A. Yes.

Q. Thank you. It says here non-narcotic analgesics are the first line agents for the management of mild to moderate cancer pain?

A. That is correct, um-uh.

Q. And, back at the time you wrote this, would you agree that that would be true for non-cancer pain as well, that non-narcotic analgesics were the first line agents for the management of mild to moderate non-cancer pain?

A. Yeah.

Q. Is that true today?

A. Again, as I describe, there are some patients who are unable to take these drugs. And these are patients who have -- who are elderly, who have renal failure or who have a variety of medical indications for why they cannot take it.

Q. To the extent that a patient does not have a contraindication for renal failure or something else for non-narcotic analgesics, would you agree that even today non-narcotic analgesics should be the first line agents for the

management of mild to moderate non-cancer pain?

A. I think that because of the evolution of our thinking about the distinctions between mild to moderate pain, I probably would say that across the board that non-opioids are the first line of agents for mild pain.

Q. Okay; and, what about moderate pain?

A. I think that we have, again, since 1985, evolved a series of agents, drugs like tramadol, drugs like buprenorphine that are being used and one might consider they could be the first line agents as well and even low dose oxycodone. And so I think there is an evolution of our thinking about that, specifically for moderate pain.

Q. And, what's low dose oxy -- when you say low dose, what do you mean?

A. Five milligrams four times a day.

Q. Do you believe that in terms of the progression of treatment that someone, if they have moderate non-cancer pain, that it's best to try a non-narcotic analgesic before you go to a low dose opioid?

A. Again, you know, I can't make a blanket statement about that. My sense would be that if a patient has moderate pain, we should start them

on a drug that treats moderate pain.

And one of the difficulties that happens to patients who have moderate pain is they are given large doses of non-opioids that are ineffective. So, one of the clinical problems we see is extraordinary side effects from high doses of non-opioids that are useful for mild pain but don't really fit the moderate pain category. And so the patient then is exposed to high doses of drugs like I.B. Profen or a variety of non-steroidal anti inflammatory drugs that have a very significant impact on the patient.

So that in a patient with moderate pain, the WHO and various other guidelines would say that those patients could be started on a weak opioid.

Q. A weak opioid being?

A. Codeine, oxycodone, hydrocodone, tramadol, buprenorphine.

Q. Do you consider OxyContin to be a weak opioid?

A. Everything is related to dose. So oxycodone in doses of five milligrams four times a day is considered a weak opioid by the WHO.

Q. So, OxyContin at what, ten milligram

dosage per 12 hours?

A. Right, would be considered within the weak opioid categories.

Q. Would you consider OxyContin at 20 milligram dosage every 12 hours to be a weak opioid?

A. Again, I think that would still fit within that category. But I would have to look that up, I am not sure. I think it would fit, though.

Q. Where would you look it up?

A. I would have to see whether -- in the studies of comparisons to morphine, since the doses of morphine that we use for severe pain were 60 milligrams of oral morphine a day, I just have to look at the comparisons there.

Q. So, back in 1985, though, you believe this statement was true, that non-narcotic analgesics were the first line agents for the management of mild to moderate non-cancer pain?

A. In 1985?

Q. Yes.

A. That's what I said.

Q. Was it true then?

A. Yes. But, it's, again, it's a general

statement with lots of exceptions to it.

Q. I am just asking you if it was true?

A. And I think my evolution of thinking about this is if patients have moderate pain, we should be treating them for moderate pain and not ask them to go through other drugs that are inappropriate.

Q. And, I don't know if you answered my question and I don't mean to keep asking the question --

A. Okay.

Q. But, do you agree with me that the statement, the general statement that non-narcotic analgesics were the first line agents for the management of mild to moderate non-cancer pain, that was true in 1985?

A. I think that I would -- that was what I said in 1985. I think my evolution of thinking about this is that I would change that sentence and it would read non-narcotic analgesics are the first line agents for the management of mild cancer pain.

Q. And, the last part of that paragraph says, in contrast to narcotic analgesics, non-narcotic agents do not cause tolerance or

physical dependence?

A. That is correct.

Q. That's as true today as it was in 1985?

A. That's -- yeah. Yes.

Q. Narcotic analgesics can cause physical dependence, correct?

A. I am sorry?

Q. Narcotic analgesics can cause physical dependence?

A. Yes.

Q. And, would you agree with me that there are many patients who might consider physical dependence to be addiction?

MR. HOFFMANN: Object to the form of the question. Answer it, if you can.

BY MR. COLANTONIO:

Q. Do you understand my question?

A. Well, most patients don't know what physical dependence is so --

Q. That's another way of me asking the question, I guess. Do you agree with me that most patients don't have a good understanding of what physical dependence is, the way you would explain it?

A. Well, first of all, every patient that I

start on a narcotic, I explain to them what physical dependence is. So --

Q. Well, and that's fair enough. If your understanding of what patients might perceive would be limited to just your practice, that's fine. We have talked a little about this and I think you would agree with me that there is confusion out there among even physicians about the terms physical dependence, addiction, psychological dependence, things like that, is that true?

A. Yes, there is.

Q. Would you agree with me that if physicians are confused about that, it might be fair to assume that patients would also be confused about those terms?

A. That's true, yes.

Q. And, wouldn't you -- you have dealt with a lot of patients in your practice; haven't you?

A. Yes.

Q. And, you have perceived how patients perceive their disease process and medications and things like that. You have had a lot of experience doing that; haven't you?

A. That is correct.

Q. And, wouldn't you agree with me that based upon your own experience with patients that most patients would equate the kinds of things that happen when you have physical dependence, withdrawal, they would equate those kinds of things with the concept of addiction?

A. You know, I don't think I would agree with that part. I think patients don't know what is happening when, let's say, they are in withdrawal so they report the phenomenon of withdrawal. So, in that setting, again --

Q. Then you explain it to them -- I am sorry, I didn't mean to interrupt you.

MR. HOFFMANN: You can go ahead and finish your answer, if you haven't.

THE WITNESS: In that setting, that we tell patients that if they take and are placed on a narcotic on a chronic basis, that they can't simply stop the drug, that they have to be tapered off it because they develop what's called a physical dependency. And so that's part, again, of explaining that to the patient.

BY MR. COLANTONIO:

Q. And, you would agree that physical

dependence can be an adverse consequence to a patient taking an opioid?

A. I don't think -- if patients are taking their medication as prescribed and have effective treatment for their pain and tapered off their drug, they never even know what physical dependence is. So it's not an adverse effect for them.

Q. Do you know any patients who have ever reported physical dependence?

A. They have -- I have had patients who for some reason or other stopped taking their drug and developed signs and symptoms of withdrawal. And they report the nervousness and irritability but -- they report those symptoms, yes.

Q. And, you know what physical dependence can cause in a patient as far as withdrawal?

MR. HOFFMANN: Object to the form of the question.

BY MR. COLANTONIO:

Q. I mean, do you understand what types of things withdrawal can cause in a patient?

A. There is a characteristic syndrome of withdrawal that depends on the drug that the patient is taking. And so in that setting, the

patient can experience a variety of symptoms.
Q. Like what?
A. Nausea, increased pain, sweating, increased blood pressure.
Q. Vomiting?
A. Some can vomit.
Q. If that occurs to a patient, those are --
A. Those would be discomforting to the patient.
Q. I will use the word discomforting. Would you agree that the possibility of physical dependence might be a reason for a physician to try non-narcotic analgesics as a first line agent in the management of mild to moderate non-cancer pain?
A. Again, I think that the -- how a physician chooses an analgesic regimen should be first dependent on the intensity of pain. So, the first rule and the guidelines that every group has written, from the WHO to the American Pain Society, is that in the choice of an analgesic regimen for a patient, one starts with the intensity of pain.
Q. And, that's the patient's report of

pain?

A. That's the patient's report of pain and then the physician's assessment of the validity of that and the association of that with a variety of other factors.

Q. Okay; getting back to this article, you wrote here at the end that paragraph where it says, non-narcotic agents, in contrast to narcotic analgesics, non-narcotic agents do not cause tolerance or physical dependence?

A. That is correct.

Q. Why were you writing that in the same paragraph that you wrote non-narcotic analgesics are the first line of defense in the management of mild to moderate --

A. It's just an important piece of information that doctors would want to know. It's obvious too, it's well-known.

Q. It's well-known but in writing that in the same paragraph that you wrote non-narcotic analgesics are the first line agents, wasn't that intending to say, one of the reasons why they are the first line agents is because in contrast to narcotic analgesics, non-narcotic analgesics do not cause physical tolerance, dependency?

A. No, it had nothing to do with that.
Q. It's in the same paragraph?
A. Yeah, it's a very vital important piece of information that doctors would want to know about the drug and it's unrelated to the first sentence.
Q. If you go to the next page which is page 88, on the bottom of the left column, the last paragraph there, it starts out, traditionally the narcotic analgesics have been used to manage acute pain. Long term use has been discouraged because of development of tolerance, physical dependence and psychological dependence and that was true in 1985; is that correct?
A. That was very true in 1985.
Q. Is that very true today?
A. No, that is not. That's where the really major difference has occurred in the whole field of pain management.
Q. Because what is happening today is people were using narcotic analgesics more than they did in 1985 to treat chronic long term pain; is that correct?
A. I don't -- could you say that again for me?

Q. Well, it says here long term use has been discouraged. This is in 1985?

A. Right.

Q. And, is long term use being encouraged today, is that the difference?

A. Long term use has been discouraged because of the development of tolerance, physical dependence and psychological dependence. What has happened since 1985 is rather extraordinary. We have had this opportunity for what one might call a natural experiment where in the setting of patients with cancer pain, we have had this opportunity to use chronic opioid therapy.

And what we have seen is that tolerance is not a significant problem. Physical dependence was not a significant problem nor was psychological dependence. So we have now this, let's say, 19 year experience of large doses of opioids being given to large populations of patients, many of whom are still alive today, in which tolerance was not a problem, physical dependence was not a problem and psychological dependence.

So that's the first opportunity in medicine that we have ever had to give chronic

opiate therapy to a large population around the world and show that these kinds of phenomenon that were attributed to opioids and described in an addict population didn't happen in a chronic medically ill population.

Q. Are there studies that you are referring to?

A. These are published studies, yes.

Q. What published studies are you referring to?

A. I have written a series of papers on the constructive tolerance and on the -- so there are studies that we have written on and given case demonstrations of patients who remained on stable doses of opioids for long periods of time without dose escalation. So that's one study.

Q. Is that the 38 case study?

A. No, it was not that study. That was in non-cancer pain but it is in a series of books and I can read it off my CV for you.

From the psychological dependence which is the language that I was using to describe addiction because that's how the WHO uses that language, Charles Cleland has demonstrated that between 1990 and 1996, with a dramatic increase

of availability of Morphine around the world and specifically in the United States, there was no increased incidence of abuse of the drug. So that was another very very strong association with demonstrating that abuse did not occur.

Q. Now, you just used, in terms of talking about psychological dependence, the word abuse. Is there a relationship between abuse and addiction?

A. Yes, there is.

Q. And, that relationship is what?

A. Unclear, no one fully understands what the relationship is. There appears to be a relationship.

Q. But, you do believe, as you sit here today, based upon your background, training and experience, there is some relationship, yet undefined, between abuse and addiction?

A. I guess to answer that question, I would have to know what you mean by abuse.

Q. Well, I will ask you.

A. What I mean by abuse?

Q. What do you mean by abuse? I would think that abuse would be using a drug in a way that is not prescribed. Is that too simplistic?

A. Well, that talks about a patient issue. If we talk about it as a societal issue, it means that the drug is being sold in an elicit market. So, Dr. Cleland looked at the issue of the drug being sold in an elicit market and demonstrated that there was not.

Q. But, do you agree that abuse can also occur in the context of a prescription in that patient?

A. Yes, it can.

Q. Again, getting back to my question, would you agree that there is some relationship between drug abuse and drug addiction or drug psychological dependence?

A. Well, some people -- I mean, yes.

Q. And, do you equate psychological dependence with addiction?

A. I do.

Q. They are synonymous in your mind?

A. For me they are synonymous.

Q. In the next paragraph, this is on the right column --

A. Um-uh.

Q. First full paragraph down the page, it says because of the misconception by both

clinicians and patients, the physical dependence and addiction are interchangeable terms. I think that's what we were talking about a little bit here before, that both clinicians or physicians and patients often confuse physical dependence and addiction.

Was that -- when you wrote that statement, was that something you believed in 1985?

A. Yeah, it was very common in 1985. I think it's again much improved now because there has been such an extraordinary amount of education related to this whole discussion.

Q. I am not trying to interrupt. I will let her finish and if I ever try to interrupt, please tell me to stop. That's not my intention.

A. It's not my intention to tell you what to do.

MR. HOFFMANN: It is mine.

MR. COLANTONIO: You can suggest it.

BY MR. COLANTONIO:

Q. But, are there any -- are you aware of any studies that have looked at the issue of how patients confuse or don't confuse physical dependence and addiction?

A. Well, there are studies that demonstrate that one of the barriers to patients taking opioid analgesics is their concern that they will become an addict, okay.

Q. And, that's true today, right, as far as you are aware?

A. Except, again, since the studies were done in the eighties and have subsequently been repeated, the concern about addiction seems to be dropping down specifically. When it was one or two in patient's minds, it is now moving down to four or five as patients become more understanding and have greater expectations for treatment of their pain.

Q. And, where do you believe the patients have gotten this, have gotten the information that has caused this change? Would it be from physicians?

A. If you look at the field of pain research from 1974 to the present time, the International Association for the Study of Pain which had, you know, 300 members in 1974 and now has 8,000 members, the number of pain services throughout the country has dramatically expanded. Research in pain has dramatically

expanded. Attention to pain as a serious public health issue has dramatically expanded.

The World Health Organization has promulgated very strongly the need for better treatment for pain and for the distinction. The International Narcotics Control Board has put out a variety of guidelines. The American Medical Association, the American Academy of Neurology, the Academy of Family Physicians, have all done elaborate educational programs because pain is seen as a serious issue.

And, most importantly now, the JCAH has demanded that as part of an accredited hospital system, the pain must be assessed and these educational materials are now in all hospitals. Institutional quality improvement programs are occurring in hospitals or around the country as we speak.

So, there has just been this extraordinary explosion of a pain science and pain research and pain experts who are focusing on trying to develop better treatment. So that's where it has come from.

Q. But, most patients don't go around reading World Health Organization statements and

these kinds of papers. Would you agree that the information that the patients are getting to change their perceptions would come from physicians or drug companies when they get prescriptions?

A. Well, they come, also, I think importantly, they come from the American Cancer Society. They come from the American Pain Foundation. They come from a variety of sources that are not from the pharmaceutical industry as well.

Q. But, the pharmaceutical industry would be one source?

A. No question, the pharmaceutical industry is a source of that, sure.

Q. To the extent that the pharmaceutical industry conveys information to physicians and then physicians convey that information to patients, that would be another source of information about these issues?

A. That's potentially another source. But I think I must say that really the JCOAH, as an example, every patient who enters the hospital or every patient who is in a nursing home or seen in an outpatient facility has to have their pain

measured. And that institution has to tell the patient that they have a right to pain management and that institution has to tell the patient what their options for treatment are.

So that kind of material is coming very much out of an institutional health care system approach. The agency for health care quality and research has developed guidelines that have been widely disseminated to patients. So there is an extraordinary amount of government and non-partisan, non-biased information available.

Q. If you look at page 88, on the right hand column -- this is about mid page.

A. Um-uh.

Q. And, the paragraph that starts, the long term use of narcotic analgesics --

A. Um-uh.

Q. -- administered orally, down about ten or 12 lines or so, there is a sentence there that says drug use is not the sole factor in the development of psychological dependence. Do you see that?

A. Yes.

Q. And, you believed that in 1985, is that correct?

A. Yes, I do. I still believe it now.
Q. Then it says psychological, social and economic factors also play a part. Do you see that?
A. Yes.
Q. And, you believed that in 1985; is that correct?
A. That is correct.
Q. And, you believe that today, is that correct?
A. I do, yes.
Q. And, psychological dependence as used in that sentence is synonymous with addiction; is that correct?
A. Yes, that is correct.
Q. I would like to show you another article or paper that I believe that you authored with Russ Portenoy, if you could take a look at that?
A. Um-uh.
Q. This article looks to be around 1985. Is that true?
A. Yes, um-uh.
Q. And, this article is titled chronic use of opioid analgesics in non-malignant pain, a report of 38 cases?

A. Right.

MR. HOFFMANN: Excuse me, Mark, you haven't been marking any of these exhibits to the deposition.

MR. COLANTONIO: I haven't.

MR. HOFFMANN: I would like to have them marked. So can we go back and mark the article that she talked to just a minute ago as Exhibit 1 and then this one as 2?

MR. COLANTONIO: We will mark a clean copy up to 47, how's that?

MR. HOFFMANN: That's fine.

(Whereupon, Plaintiff's Exhibits 1 and 2 were marked for identification.)

MR. COLANTONIO: He has about three minutes left on the tape.

MR. HOFFMANN: So why don't we take a break.

MR. COLANTONIO: Yeah, let's do that.

THE VIDEOGRAPHER: Going off the record, 9:25, end of tape number one.

(Whereupon, a brief recess was taken.)

THE VIDEOGRAPHER: Returning to the record, 9:40 a.m., beginning of tape number two.

BY MR. COLANTONIO:

Q. If you can look at the article in front of you now, we will mark that as Exhibit 2. That's the -- the title is chronic use of opiate analgesics in non-malignant pain, report of 38 cases. Do you see that?

A. Yes.

Q. And, you were a co-author of that article; is that correct?

A. That is correct.

Q. And, this was back in 1985; is that true?

A. Yes.

Q. This is while you were at Sloan-Kettering; is that right?

A. Right. I have only been at Sloan-Kettering.

Q. That's probably a poor way to phrase the question. If you would look back at page 183, there is a section that talks about guidelines. Do you see that?

A. Yes. Well, guidelines, okay.

Q. Do you see that?

A. Yes.

Q. As I read this, this appears to me to be

sort of a summary of guidelines that were proposed by you for the use of opioid maintenance therapy at that time. Is that a fair reading of that or --

A. Well, this is a paper of individual cases in which we then said we were proposing how you might think about developing guidelines, you know. I don't think two doctors can develop guidelines, necessarily.

Q. But, you were proposing some guidelines, I presume?

A. That is correct, yes.

Q. Based upon your experience with patients?

A. That is correct.

Q. All right; the first sentence under guidelines says, opioid maintenance therapy should be considered only after all reasonable attempts at pain control have failed and persistent pain is the major impediment to improve function?

A. Um-uh.

Q. And, that was true in 1985. That was your thought in 1985; is that true?

A. That was what we thought in 1985.

Q. And, do you still think that today?

A. Again, this is all evolving because, as I said in 1985, we didn't have treatments we have now for patients with pain. So we didn't have in 1985 spinal cord stimulators. We didn't have interphecal (ph) opioids. We didn't have documented drugs like Neurontin. We didn't have a variety of other approaches. So the sort of technology of treating pain has changed.

And at the same time, we still didn't have the experience that we have now with opioids in 1985. So, what's evolved is that, all reasonable attempts at pain control have failed would imply that the patient had to have every one of them.

And I think we are coming to recognize that patients should not have nerve blocks unless they need them. Whereas in 1985 it was believed that they should be sent off for nerve blocks, that they shouldn't have surgery -- that they should try surgery or cordotomy before you tried opioids.

And what has evolved now is that those procedures such as cordotomy which one of these patients had or nerve blocks that some of these

patients had would not necessarily have to be tried because they weren't really indicated. So the state of the science of pain management is so evolving and so different that I think we are focusing on saying that patients -- that opioid maintenance therapy should be instituted but not as a last resort.

And, this has now been taken into the intractable pain laws and why intractable pain laws now as well as in the State of West Virginia say that the patient doesn't have to have all attempts, they have to be reasonable attempts. And so I think I might take out the word all.

Q. But, if you take out the word all, that statement would be true today, that is, opioid maintenance therapy should be considered only after reasonable attempts at pain control have failed and persistent pain is the major impediment to improved function?

A. I think I would add more to that and that is that the cause of the pain can't be treated because that's how the intractable pain laws have been written. So, I think the language in the intractable pain laws, which I think West Virginia has adapted a good one, would fit.

Q. But, certainly a reasonable attempt at controlling pain would be the use of non-opioid medication?

A. Absolutely not.

Q. Absolutely not?

A. Absolutely not.

Q. You think that the use of a non-opioid medication is an inappropriate, unreasonable way to attempt to control pain?

A. I do because if a patient has severe pain, you would not give them a non-opioid. That would be an inappropriate choice.

Q. What if they have mild pain?

A. If they have mild pain, it would be an appropriate choice. If they have mild to moderate pain, it would not necessarily be an appropriate choice.

And, if they took non-opioids and it failed -- but this is a misconception that is of great concern to me. There is a belief that every patient has to start with a non-opioid and then go to an opioid. And the WHO ladder was not conceived like that. It was identify the patient on the intensity of pain and treat them with the drug for that intensity of pain, so --

Q. I am sorry, are you finished?
A. No, I am not finished. So that if a patient has severe pain, it would be inappropriate therapy to give them a non-opioid.
Q. So, this statement you made in 1985 simply just doesn't fit in today's --
A. That's not what I said. My statement here is I would say that I would take out the word all reasonable. I would just say reasonable attempts. And that I would, again, because of the evolution, I would go more strongly with how the intractable pain laws have thought about this, is the sense of that you have -- that you are unable to treat the cause and that reasonable attempts at treatments have failed.
Q. You are talking about intractable pain. Let's talk about mild to moderate pain, do you think it --
A. Intractable pain can be mild, moderate or severe.
Q. I am sorry, I didn't finish my question. If you would let me finish my question, give me that courtesy. I will give you the same courtesy to finish your answer.
A. I am sorry.

Q. In terms of mild to moderate pain, would you agree that a reasonable attempt at controlling that pain would be using a non-opioid?

A. For mild pain, yes.

Q. There is another sentence here under guidelines on the next paragraph, it says the committed involvement of a single physician who will evaluate ongoing medical and psychological problems as well as pain related issues should be available before institution of opioid maintenance therapy is considered. Do you see that?

A. Yes.

Q. And, that was true in 1985; right?

A. Um-uh.

Q. Is that true today?

A. Yes, it is, except that because so many people practice in a group practice or in a pain clinic, I could say the committed involvement of a pain treatment program, of a physician group would be -- who knew the patient and followed the patient, would be it. So it wouldn't have to be a single physician, it could be a group of physicians.

Q. You would agree it is kind of difficult for an emergency room physician to follow a patient because they see them in an emergency room setting?

A. I would agree with that.

Q. And, that's also true sometimes for primary care physicians, like family doctors, because often times they might see a patient once or twice and they might refer them to somebody else?

A. I don't think I could comment on that. It seems if they are a family doctor, then they are the family doctor and they see them all the time.

Q. If you go to the next page, page 184, still under guidelines, the top of the page, first full sentence says, since many patients with non-malignant pain can achieve only partial relief from opioid drugs, while others obtain none, a physician must be able to make the clinical judgment that higher doses will not be solitary or the treatment should be stopped all together. Now, what did you mean by that?

A. Again, this was sort of an evolving construct. This paper was written -- do you want

to hear all this?

Q. I actually just want to know what you meant by it and then I could ask you -- and if you need to explain the whole history of it to answer my question, I suppose you can do that.

A. I think I do, okay. This paper was written at a time that it was believed that there were certain types of pain that were resistant to opioid drugs and that was an evolving belief. And patients in this population were patients that would be then categorized as resistant to opioids.

And that we then went on, Dr. Portenoy and I, and Dr. Teresi (ph) to write a paper and do studies looking at a concept of opioid responsiveness. And so what we promulgated was a concept that there is a continuum of opioid response. So, if you just give a set dose of drug to a patient, they may not respond. But if you increase the dose, the patient would obtain analgesia.

This sentence is describing these patients in this paper who only had partial relief and we had to make a decision should we try a higher dose to see if they obtain more

relief or should we stop their drug because it is ineffective. That was what this is bringing up, a real clinical issue.

And, so, we have gone on to give higher doses of drugs to patients in a study paradigm and show that they did in fact respond. And that this concept of opioid responsiveness is a continuum and the limiting factor is the patient's ability to not only obtain analgesia but to have significant side effects.

Q. One of those side effects might be physical dependence?

A. No, the side effects would be sedation. The side effects would be nausea and vomiting, confusion, delirium, those kinds of side effects.

Q. The next sentence, one of the next sentences down here in the paragraph says, the appropriate management of opioid maintenance requires the patient be given fully informed consent. Do you see that?

A. Yes, that the patient gives fully informed consent.

Q. And that's true today; correct?

A. Again, there are some state guidelines that say patients should have a fully informed

consent and there are others that do not. I think all of the guidelines that are now being written for the management of patients with non-malignant pain suggest that the patient be fully informed. Whether the patient actually signs a consent form or has a contract with the physician is still very debatable.

Q. And, this sentence doesn't talk about a contract, the next one, does it. I am just asking you if you believe today and would agree that a patient should be given fully informed consent before being placed on an opioid?

A. But, I think the sentence says that the patient gives fully informed consent. You are using given, I am just --

Q. Doesn't the patient have to be given it to actually give it, I mean --

A. Then the doctor gives the information so I am just reading what we wrote.

Q. Let's look --

A. So, this is what I wrote.

Q. I am not trying to complicate it.

A. Fine, but I am just --

Q. And, sometimes I guess my questions might sound simplistic. I am just trying to

understand what you meant by this.

The sentence says, the appropriate management of opioid maintenance requires that the patient gives fully informed consent. And you agree that that's also true today. Whether it is required by some state law or not, you agree that the patient should still today give fully informed consent?

A. Yes.

Q. And, would you agree that part of giving fully informed consent means the patient has to have enough information given to them to give fully informed consent?

A. Yes.

Q. And, part of the obligation of doing that rests on the part of the drug manufacturer; true?

A. It would seem to me that it only rests on the physician who prescribes the drug.

Q. Well, isn't it an obligation though -- the physician is the one who is there treating the patient, giving information to the patient. But don't you agree that the drug manufacturer has an obligation to provide the physician with the information that will enable the physician to

give the patient informed consent?

A. I think I see it residing with the physician, however the physician gets this because he could get it from the government. He could get it from JCOAH. He doesn't have to get it from the drug company. I would hope he didn't get it from the drug company. I hope he got it from a lot of other sources.

Q. So, you don't believe that the drug manufacturer plays any role or has any responsibility to provide physicians with information in this process of insuring that patients give fully informed consent for opioid treatment?

A. I think the physician is the person who is responsible when he writes the prescription.

Q. I understand what you are saying but that's not really my question.

A. Okay.

Q. My question is don't you agree that the manufacturer has an obligation to provide the physician with the information so the physician can then give it to the patient?

A. Well, I think that's -- I don't want to say that it's a responsibility. It's the

responsibility of the physician to know about the drug that they prescribe and they can use a variety of sources.

Q. Well, I understand that. A physician can read. A physician can get different sources but don't you think the manufacturer plays a part in that?

A. The manufacturer plays a part in making sure that the information that is appropriate has been approved by the FDA so that the physician can rely on what the FDA has said about the drug.

Q. Do you believe the manufacturer should provide the physician with fairly balanced information about a drug?

A. I do, yes.

Q. And, a manufacturer shouldn't misstate or misrepresent information about a drug to a physician. Do you agree with that?

A. I agree with that.

Q. Now, the next sentence in your page 184 of your article talks about this article from Tennant & Olman?

A. Yes.

Q. And, they recommend written, formal written consent be obtained or a detailed

notation made in the patient's chart which documents that the patient has failed non-narcotic therapy and enters knowingly into a trial opioid maintenance?

A. Right.

Q. Did you cite that because you cited that with approval at that time in 1985?

A. I am sorry, I cited it because it was in the literature and I cite things that are in the literature whether I agree with them or not.

Q. There were a lot of things in the literature in 1985. I presume there were lots of journals out there but you picked this particular citation and this sentence to put in your article which is only, I don't know, 15 pages long. You didn't pick out other citations.

So, I presume that means that you agreed with that. Is that wrong? And this is in the guidelines section.

A. That's incorrect. It is not anything about agreeing with it. We were in a very unbiased way writing about what was in the literature and there weren't ten or 15 or 40 other articles. There were very few and you can see why there were very few referenced.

So these were people who had the experience of treating patients with chronic non-malignant pain and this was their suggestion.

Q. Did you disagree with that in 1985?

A. We are just -- I was not in a position to agree or disagree. We were telling -- we were giving suggestions of what people had suggested.

Q. And I understand that.

A. So that's all I can say.

Q. I fully understand that but I am asking you a different question, now. I am asking you if you agree or disagreed with that in 1985; that's all?

A. I didn't have to agree or disagree with that. I was just describing it.

Q. I understand you were describing it and writing it. I am just asking you if you disagreed with that?

A. I think that I have concerns about the use of contracts with patients.

Q. And, your concerns are what?

A. And they are very serious, is that it seems that we are wanting to make contracts for poor people and minorities and not for white people at major academic centers. So that sickle